29-000 FEDERALLY-QUALIFIED HEALTH CENTERS (FQHC'S)

29-001 Standards for Participation: To be considered a federally-qualified health center (FQHC) for the Nebraska Medical Assistance Program, as allowed by section 6404 of P.L. 101-239, a health center must furnish proof that the United States Public Health Service has determined that it is qualified under Sections 329, 330, or 340 of the Public Health Service Act, or that it qualifies by meeting other requirements established by the Secretary of the Federal Health and Human Services.

29-002 Services Provided for Clients Enrolled in the Nebraska Health Connection (NHC): Certain NMAP clients are required to participate in the Nebraska Medicaid Managed Care Program known as the Nebraska Health Connection (NHC). See 471-000-122 for a listing of the NHC plans.

29-002.01 Health Maintenance Organization (HMO) Plans: The NHC HMO plans are required to provide, at a minimum, coverage of services as described in this Chapter. The prior authorization requirements, payment limitations, and billing instructions outlined in this Chapter do not apply to services provided to clients enrolled in an NHC HMO plan with the following exceptions:

1. Medical Transplants: As defined under 471 NAC 18-004.40, transplants continue to require prior authorization by NMAP and are reimbursed on a fee-for-service basis, outside the HMO's capitation payment;
2. Abortions: As currently defined, abortions continue to require prior authorization by NMAP and are included in the capitation fee for the HMO; and
3. Family Planning Services: Family planning services do not require a referral from a primary care physician (PCP). As defined in 471 NAC 18-004.26, the client must be able to obtain family planning services upon request and from a provider of choice who is enrolled in NMAP. Family planning services are reimbursed by the HMO, regardless of whether the service is provided by a PCP enrolled with the HMO or a family planning provider outside the HMO.

Services provided to clients enrolled in an NHC HMO plan are not billed to NMAP. The provider shall provide services only under arrangement with the HMO.

29-002.02 Primary Care Case Management (PCCM) Plans: All NMAP regulations apply to services provided to NHC clients enrolled in a PCCM plan. For services that require prior authorization under 471 NAC 18-004.01, the provider shall obtain prior authorization from the PCCM plan under the directions for prior authorization of the PCCM plan with the following exceptions:

1. Medical Transplants: As define under 471 NAC 18-004.40, transplants are subject to prior authorization by NMAP; and
2. Abortions: As currently defined, abortions require prior authorization by NMAP.

29-002.02A Referral Management: When medically necessary services that cannot be provided by the PCP are needed for the client, the PCP shall authorize the services to be provided by the approved provider as needed with the following exceptions:

1. Visual Care Services: All surgical procedures provided by an optometrist or ophthalmologist require approval from the PCCM plan. Providers shall contact the client's PCCM primary care physician before providing surgical services. Non-surgical procedure provided by an optometrist or ophthalmologist do not require referral/approval from the PCP; however, when an optometrist or ophthalmologist diagnoses, monitors, or treats a condition, except routine refractive conditions, the practitioner shall send a written summary of the client's condition and treatment/follow-up provided, planned, or required to the client's PCP.
2. Dental Services: Dentists or oral surgeons providing medically necessary services not covered under 471 NAC 6-000 shall bill that service on Form CMS-1500 or electronically using the standard Health Care Claim: Professional transaction (ASC X12N 837), using HCPCS/CPT procedure codes. These services require referral/ authorization from the client's PCP. The provider shall contact the PCP before providing these services. If a client requires hospitalization for dental treatment or for medical and surgical services billed on Form CMS-1500 or electronically using the standard Health Care Claim: Professional transaction (ASC X12N 837), the provider shall contact the PCP for referral/authorization.
3. Family Planning Services: Family planning services do not require a referral from the PCP. As defined in 471 NAC 18-004.26, the client must be able to receive family planning services upon request and from a provider of choice who is enrolled in NMAP.

29-002.03 Mental Health and Substance Abuse Services Mental health and substance abuse services (MH/SA) are provided by the MH/SA managed care plan for all NHC clients. This plan includes the Client Assistance Program (CAP). Clients may access five services annually with any CAP-enrolled provider without prior authorization. All other MH/SA services must be prior authorized by the Plan.

29-003 Payment for Services Provided by FQHCs: Effective April 1, 1990, the Nebraska Medical Assistance Program (NMAP) makes payment for services provided by federally-qualified health centers (FQHCs) as defined in section 1905(a)(2)(C) of the Social Security Act on the basis of reasonable costs allocated to the care of Medicaid-eligible clients.

29-003.01 Definitions: The following definitions apply in this chapter.

Encounter: A face-to-face visit between a Medicaid-eligible patient and a physician, physician assistant, nurse practitioner, nurse midwife, specialized nurse practitioner, visiting nurse, clinical psychologist, or clinical social worker during which an FQHC service is rendered. Encounters with more than one health professional and multiple encounters with the same health professional which take place on the same day and at a single location constitute a single visit, except for cases in which the patient, subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment.

Encounter Rate: The all-inclusive rate that the Department reimburses the FQHC for an encounter. The encounter rate shall be determined by dividing the total reasonable costs allocated to Medicaid-eligible patients from the FQHC's latest cost report by the total number of encounters by Medicaid-eligible patients during that same time period.

Encounter Payments: The total dollars paid to the FQHC by the Department based on the number of encounters billed and paid at the encounter rate.

Interim Payments: Payments made by the Department to an FQHC which are subject to the cost reconciliation process. The payments may be encounter payments and/or payments made based on the Nebraska Medicaid Practitioners Fee Schedule.

Reasonable Costs: Determined by the Department on the basis of the FQHC's cost report, submitted as the Medicare cost report (Form HCFA-2552) or any other cost reporting form approved by the Department for this use. Such costs cannot exceed the reasonable costs as determined by the applicable Medicare cost reimbursement principles set forth in 42 CFR Part 413.

Providers participating in the NMAP as FQHCs must submit a plan for allocating costs to the NMAP program. This plan must also indicate the annual cost reporting period by which the FQHC plans to report its annual costs to the Department.

29-003.02 Cost Reconciliation Process: Interim payments will be subject to reconciliation at the end of the cost reporting period. Following the receipt of the FQHC's Medicare cost report (or other acceptable cost reporting form), the Department will compute a retroactive adjustment to the allowable Medicaid costs for the cost reporting period.

The Department will make additional payment to the FQHC when the allowable reported Medicaid costs exceed the interim payments made to the FQHC. Payments will be made within 90 days of receipt of the cost report by the Department.

The FQHC must reimburse the Department when its allowable reported Medicaid costs for the cost reporting period are less than the interim payments. Payments owed to the Department must be made within 90 days following notice by the Department to the FQHC of the amount due.

29-004 Billing for FQHC Services: FQHCs shall bill for their services on Form CMS-1450 (see 471-000-51) or electronically using the standard Health Care Claim: Institutional transaction (ASC X12N 837). FQHCs shall use the appropriate HCPCS/CPT procedure codes and revenue codes when billing for services.

FQHCs shall bill for HEALTH CHECKS (Early and Periodic Screening, Diagnosis, and Treatment-EPSDT-Exams) on Form CMS-1500 (see 471-000-58) or electronically using the standard Health Care Claim: Professional transaction (ASC X12N 837).